EXHIBIT A

PRELIMINARY REPORT OF DR. EVERETT MCDUFFIE, MD
October 9, 2020
***Hurd v. Lye, et al*, 2:19cv760**

I. QUALIFICATIONS

My name is Everett Ellison McDuffie, M.D., F.A.P.A. I am a physician specializing in psychiatry and the subspecialty of forensic psychiatry. I graduated from the University of Alabama with a bachelor's degree, and obtained my M.D. from American University of the Caribbean School of Medicine in 2000. Thereafter, I completed both an internship and part of a residency program with the University of Alabama at Birmingham School of Medicine, Family Medicine Residency Program. In 2007, I completed a Psychiatry Residency Program at East Tennessee State University, Quillen College of Medicine. In 2009, I completed a Forensic Psychiatry Fellowship Program at the University of Alabama Hospital. I have been named a Diplomate in Psychiatry with the American Board of Psychiatry and Neurology in 2009, and a Diplomate in Forensic Psychiatry with the American Board of Psychiatry and Neurology in 2011. In 2014, I was awarded status as Fellow of the American Psychiatric Association.

I am currently employed under contract by the Virginia Department of Corrections, as a psychiatrist covering the Wallens Ridge and Red Onion State Prisons. I have held this position since 2012. From 2009 to 2013, I worked at the James H. Quillen VA Medical Center, as a staff physician in psychiatry. I have additionally been an Assistant Clinical Professor at the Eastern Tennessee State University-Quillen College of Medicine since 2008.

My full C.V. is attached as Appendix A to this report. My C.V. contains a comprehensive list of my publications.

I have provided testimony in the following legal matters during the last four years:

Shadle v. Nebraska Department of Corrections (transgender dysphoria in Nebraska)
Elliot v. PTW (malpractice in Virginia)

II. COMPENSATION

Compensation for my services as an expert witness is $300 per hour for time spent on record review, collateral data collection, and diagnostic instrument interpretation. Compensation for psychiatric interviews is $400 per hour or $200 per hour for interview via telepsychiatritry. Compensation for deposition, trial, or administrative hearing testimony is $500 per hour. In the event travel is necessary, compensation will be $30 per hour for time spent traveling to and from depositions or trial from portal to portal, including all time spent waiting and reasonable out of pocket expenses actually incurred for travel, including for example commercial travel, lodging, automobile rental, meals, etc.

III. BASIS OF EXPERT OPINON

I have reviewed the following records: 1) MSJ 1-990; (2) Hurd medical records from Wexford (WEX 4-102; 1568-1636; 1642-1940); (3) Wexford Medical guidelines (WEX 452-795 & WEX 1141-1264); (3) Suicide Watch Logs (WVDOC 291-302; 346-703); (4) WVDOC 424-429; 542-628; Dr. Charles Lye deposition transcript; (5) Brandon Fink Deposition Trans; (6) Timothy Carper Deposition Transcript; (7) Hurd Deposition Transcript.

In addition, I examined Dwight Hurd on 7/29/2020.

IV. SUMMARY OF OPINIONS

Mr. Hurd meets the diagnostic criteria for 2 major mental illness and a personality disorder.

- Post Traumatic Stress Disorder (PTSD)
- Conversion Disorder or Functional Neurologic Syndrome
- Personality Disorder Unspecified

It is my opinion with a reasonable degree of medical certainty that Mr. Hurd has Conversion Disorder[1] and Post Traumatic Stress Disorder. It is also my opinion with a reasonable degree of medical certainty that his current impairments with Post Traumatic Stress Disorder and Conversion disorder are a proximal result of the use of force incident while in custody in West Virginia.

V. FACTUAL BASIS FOR OPINIONS

Background for assessment is that Mr. Hurd is an African American male in his mid-30's with a history of two terms of incarceration who is unable to walk since a use of force incident while he was in custody at a prison facility in West Virginia.

Mr. Hurd has a history of physical and emotional trauma over a lifetime placing him at risk for PTSD. His current PTSD symptoms are specifically generated by triggered reminders of the use of force incident while in custody in West Virginia.

In addition to Post Traumatic Stress Disorder with depressive features, Mr. Hurd has been unable to fully recover the use of his lower extremities. He has a Functional Neurologic Syndrome which I will refer to hereafter as Conversion Disorder.
Mental status revealed a neatly dressed male in his mid-thirties with restricted affect that remained guarded throughout the interview. His mood was "stressed" and "on edge." He was well oriented to where he was, date, day, and month. Content of discussion yielded an

[1] I understand Mr. Hurd is undergoing a second MRI at the direction of his physician at Kings County Hospital Center in Brooklyn, New York, but that the results of that MRI are not yet available. Should the results of that testing indicate a neurologic basis for Mr. Hurd's loss of function in his lower extremities, I will amend this report accordingly.

estimated average to above average intellect. He was not suicidal or homicidal. He was not paranoid and no delusional content was disclosed. His thought processes where linear and coherent. Speech was clear and fluent. Insight was fair: he knows he has emotional problems. Judgment was intact. Memory testing revealed difficulties with concentration consistent with anxiety but he was able to recall three words with prompting. He was able to spell the word WORLD backwards after two attempts.

Mr. Hurd meets the diagnostic criteria for 2 major mental illness and a personality disorder:
Post Traumatic Stress Disorder (PTSD)
Conversion Disorder or Functional Neurologic Syndrome
Personality Disorder Unspecified

PTSD

PTSD is a chronic psychiatric disorder that is acquired by individuals exposed to severe or life-threatening trauma. PTSD is a condition that manifests as a constellation of symptoms across four categories: re-experiencing trauma, efforts to avoid reminders of the trauma, a restricted set of emotional responses, and hyperarousal. Re-experiencing most commonly arises in the form of nightmares and flashbacks. This destroys a person's sleep architecture over time and flashbacks are embarrassing to explain to others witnessing a person behave like they have returned to moment of experiencing trauma. Some individuals have re-experiencing problems with certain smells and the appearance of individuals that bear some likeness associated with trauma. Avoidance can impact a person's life by restricting activities leading to further isolative and reclusive behaviors. A restricted emotional response in general and over time leads to a sense of alienation that is not perceived as severe early in the illness. Over a longitudinal course, alienation and a failure to connect with people emotionally can lead to severe depressive symptoms and disability. Early in the illness, hyperarousal is prominent but is the most treatable spectrum of the illness. Hyperarousal is: insomnia, poor concentration, hypervigilance (being intensely aware of potential danger in surroundings), irritability, and an exaggerated startle response compared to most people. Hyperarousal leads to physical and mental exhaustion late in the day and anxiety generated by hyperarousal is often seen as intense paranoia. What may appear as paranoia in PTSD is often indistinguishable from intense apprehension. A high number of PTSD sufferers have major depressive symptoms and are at risk for substance abuse and suicide. Risk factors include early abuse and neglect in childhood. In general, some traumatized people develop PTSD and others do not. Hyperarousal is treated with psychotherapy and medications like commonly available antidepressants like sertraline (ZOLOFT) which has an FDA approval for treating PTSD. With combat-related PTSD being more visible in the news, its disabling and potentially fatal effects are now more widely grasped by more people.

Mr. Hurd has long been at risk for PTSD given his background of traumatic exposures. The traumatic event of a use of force incident while in custody in WV likely triggered his current problems with chronic PTSD. He has had re-experiencing symptoms in the form of nightmares and triggered reminders for over a year. He goes out of his way to avoid triggers that remind

him of the trauma and this is impossible to do since one of his triggers is being in the presence of public safety officers. He has a restricted affect and a level of alienation that may have been chronic prior to the incident of trauma in custody; his depressed outlook and isolating tendencies are recent problems that have emerged over the past two years. He has severe hyperarousal symptoms that are chronic: irritability, insomnia, hypervigilance, and an exaggerated startle response. There is no other medical explanation for his symptoms.

Conversion Disorder

Conversion Disorder (Functional Neurologic Symptom Disorder) is the manifestation of a loss of function in the nervous system without any physical explanations. The area of the body or functional loss is always neurological: loss of consciousness, convulsions (seizure), paralysis, blindness, difficulty speaking, stroke-like symptoms, and weakness. Conversion disorder is not common, about 2-5 incidences per 100,000 people per year; but it is commonly seen by neurologists and psychiatrists. Generally there is a stressor that is known or unknown to the patient and this stress results in the loss of functioning. The prognosis for conversion disorder is usually good or fair, with most patients making a complete recovery. Diagnosing conversion disorder requires that the symptoms are not feigned or voluntarily produced. In order to diagnose conversion disorder there cannot be a neurologic or physical illness that would explain the loss of function and the symptoms do not fit another mental disorder.

Mr. Hurd's Conversion Disorder symptoms are prolonged, and their onset was from the traumatic use of force incident in WV. In Mr. Hurd's case, he experienced a stressor followed by lower limb weakness and loss of sensations making him unable to walk. He has lost use of his lower extremities and there is no physical reason why he should not be able to stand and walk per his baseline prior to the use of force incident. Mr. Hurd carries many of the hallmarks of having Conversion Disorder: he is more indifferent about the loss of functioning than would be expected, there is no identifiable secondary gain to feign symptoms, and previous investigations into his problem have yielded normal findings. Although Mr. Hurd has the indifference seen in many individuals with conversion disorder, current medical thinking is that aspect of the presentation is not helpful in diagnosis. Still, it is seen in many conversion disorder patients. In reviewing records and examining Mr. Hurd I was unable to elicit any possible secondary gain. Litigation itself is stressful enough to perpetuate the condition, with the inference that he would not be in litigation unless it was absolutely necessary for his recovery.

During the functional loss it is helpful and necessary to provide assistive supports like a wheelchair if available. Physical therapy is helpful for individuals with paralysis not explained by physical findings. In my opinion, at minimum, a patient with conversion disorder or suspected conversion disorder should be referred to psychiatry or neurology if either specialty is available. In this case, Mr. Hurd could have been provided an expected prognosis and possible explanation for why he may have been experiencing lower extremity weakness and loss of sensation.

Personality Disorder Unspecified

Personality disorder unspecified: Mr. Hurd has the objective problem of failing to conform to societal norms to an extent that he has twice been incarcerated. He also has a problem with stress related paranoia. None of these two on their own equate to a specific personality disorder but either one creates a severe impairment with disastrous results. Being incarcerated reflects, at minimum, some deficit of insight into behaviors that result in legal consequences and is an anti-social feature, but he may not have anti-social personality disorder. High amplitude emotional reactions that are out of proportion and nearly psychotic that resolve quickly are a feature of borderline personality disorder, but Mr. Hurd did not appear to have a diagnosable borderline personality disorder.

It is my opinion with a reasonable degree of medical certainty that Mr. Hurd has Conversion Disorder and Post Traumatic Stress Disorder. It is also my opinion with a reasonable degree of medical certainty that his current impairments with Post Traumatic Stress Disorder and Conversion disorder are a proximal result of the use of force incident while in custody in West Virginia.

Respectfully,

Everett E McDuffie

Everett McDuffie, MD
ABPN Diplomate in Psychiatry and Forensic Psychiatry